

Shared Community Breastfeeding Standards between Lincoln Hospitals

This education and information is directed at all infants except with medical conditions including but not limited to respiratory distress, seizures, etc. who may require alteration in expectations and breastfeeding patterns during the acute phase.

1. Bryan Medical Center and Saint Elizabeth Regional Medical Center will each have a written breastfeeding policy that is routinely communicated to all healthcare staff. This will be based on current research and guidelines from the United States Breastfeeding Coalition, American Academy of Pediatrics, Academy of Breastfeeding Medicine, American College of Obstetricians and Gynecologists, American Academy of Family Physicians, World Health Organization and UNICEF.
 - a. Definition: Written policy
 - i. Each staff is expected to follow the written policy with follow-up for non-compliance.
 - ii. Reinforcement of breastfeeding policy will be addressed as needed.
 - b. Evaluation: Policy revised/evaluated every 3 years:
 - i. By both hospitals and bring back to the task force for major changes.
 - ii. Annual competencies with staff will be completed.

2. All staff caring for mothers and babies will be trained in the skills necessary to support breastfeeding based on current and consistent evidence based care.
 - a. Definition: Core Education
 - i. Importance of skin-to-skin
 - ii. Early initiation of breastfeeding
 - iii. Effective latch
 - iv. Expected feeding patterns and weight loss
 - v. Maintaining breast milk supply during mother infant separation
 - vi. Importance of exclusive breastfeeding
 - vii. Risks of non-medically indicated supplementation
 - viii. Importance of rooming-in
 - ix. Instruction on artificial nipples and pacifiers
 - x. Contraindications to breastfeeding
 - b. Evaluation:
 - i. For all staff caring for breastfeeding dyads, core education listed above must be completed by end of staff orientation
 - ii. Competency of core education will be evaluated by preceptor and/or management
 - iii. Nursing staff will have a minimum of 4 hours of supervised clinical experience (with an IBCLC) assisting with breastfeeding. This will be completed within 6 months of employment.
 - iv. Annual competencies will be completed to ensure staff competency.

3. Education will be provided to all pregnant women about the benefits and management of breastfeeding, contraindications to breastfeeding, and implications of formula feeding.
 - a. Definition
 - i. Verbal and written information will be provided in prenatal classes (i.e. childbirth, breastfeeding)
 - ii. Written information will be included in the preadmission packet given to patients in the physician offices
 1. Importance of exclusive breastfeeding
 2. Importance of early skin-to-skin contact
 3. Early initiation of breastfeeding
 4. Rooming-in
 5. Feeding patterns
 - a. First 24 hours of life
 - b. After 24 hours of life
 6. Risks of elective supplementation to breastfeeding/milk supply
 7. Limiting visitors to promote parental bonding during hospital stay
 - iii. Mother's informed feeding decision will be documented in medical record.
 - iv. Contraindications to breastfeeding and other special medical conditions will be discussed on an individual basis.
 - v. The hospital will not provide formula marketing materials to mothers and will discourage promotional material and marketing efforts in all areas accessible to patients.
 - b. Evaluation
 - i. Educators will be responsible for implementing/updating education for prenatal classes respectively.
 - ii. Preadmission packet given to patients in the physicians' offices will be evaluated every 3 years and/or updated as needed.

4. All healthy newborns will be placed and remain in direct skin-to-skin contact with their mothers immediately after delivery until the first feeding is accomplished, unless medically contraindicated, including cesarean births.
 - a. Definition-Skin-to-skin is the act of placing the dry, undressed infant against the bare skin (no bra) of the mother's chest. Then mother and baby are covered, except baby's head, with warm blankets.
 - i. Place infant skin-to-skin immediately after birth without interruption until first feeding is accomplished. In cases of cesarean birth immediate skin-to-skin should be initiated as soon as possible after delivery and can be done while incision is being closed.
 - ii. The infant should not be removed for routine assessments, bathing, medications, during procedures which may be painful, or during mother/infant transport. Cord clamping and APGAR scoring can be done with the infant skin-to-skin.
 - iii. If skin-to-skin is delayed due to medical necessity, resume skin-to-skin as soon as medically possible.
 - iv. Skin-to-skin contact should be encouraged throughout the hospital stay.
 - b. Evaluation
 - i. Skin-to-skin contact will be documented in the medical record
 - ii. The evaluation of the process will be performed as needed by each facility

5. All mothers will be shown how to recognize effective breastfeeding and how to maintain lactation if separated from their infant(s).
 - a. Definition: Effective latch, feeding patterns, maintaining milk production, hand expression, infant intake and output, and follow-up.
 - i. Staff will instruct breastfeeding mothers about:
 1. Proper positioning and latch.
 - a. Mom should be relaxed and comfortable
 - b. Baby should be well supported with infant's chest and hips facing mother
 - c. Baby's lips should be flanged outward
 - d. Cheeks should be full and round, no dimpling noted
 - e. No audible clicking or smacking while suckling
 - f. Latch should not be painful
 2. Nutritive suckling and swallowing.
 - a. Initial rapid suckle transitioning to long rhythmic suckles of the jaw into the temple region. Nutritive sucking can be encouraged by breast compressions, frequent stimulation of the infant, and skin-to-skin.
 - b. Intermittent swallowing less than 48 hours of life and frequent audible swallowing greater than 48 hours of life.
 - c. Non-nutritive suckling is defined as short rapid sucks with minimal swallowing noted.
 3. Infant feeding patterns.
 - a. Mothers will be instructed to feed their baby on demand with 8-12 feeds in 24 hours, avoid scheduling feeds.
 - b. Mothers will be instructed to avoid time limits for breastfeeding on each side. Infants can be offered both breasts at each feeding but may be interested in feeding only on one side at a feeding during the early days.
 - c. Mothers will be able to recognize infant feeding cues. Indicators of hunger are; increased alertness or activity, smacking, rooting, or bringing hands to the mouth. Feed at the first signs of hunger, crying is a late sign of hunger.
 4. Maintaining milk production.
 - a. Frequent stimulation to both breasts (8-12 times per day around the clock) through direct breastfeeding and/or pumping, if baby is unable to successfully latch or mother/infant are separated.
 5. Hand expression of milk and use of a pump if indicated.

- a. Mothers will be instructed on how to effectively hand express breast milk. When indicated, instruction will be given on proper set-up, use, and cleaning of breast pump per manufacturer guidelines.
 - b. Hand expression/pumping will be used when direct breastfeeding cannot be accomplished (i.e. separation from baby, ineffective latch, sore/healing nipples)
 - i. If after 12-24 hours of life the infant has not latched or fed effectively, the mother will be taught to hand express or pump colostrum every 2-3 hours around the clock until effective feeding patterns are established. Any expressed breast milk shall be fed to the infant by cup, syringe, or SNS.
 - ii. If mother and infant are separated, expression by hand or pump shall be initiated within 3-6 hours of life and continued every 2-3 hours around the clock until effective feeding patterns are established. Mother should express both breasts for 15 minutes.
 - c. Mother will be instructed on the correct collection and storage guidelines of freshly expressed breast milk. Written guidelines will be provided at discharge.
 - d. Mother will be reminded that she may not obtain much milk or any milk the first few times she expresses her breasts.
6. Normal infant intake and output:
- a. Normal breast milk volumes
 - i. Breast milk volumes continue to increase each day relative to increasing infant stomach capacity.
 - 1. Day 1 (Birth – 24 hours): drops to 5 cc per breastfeeding session
 - 2. Day 2 (25 – 48 hours): 5-10 cc per breastfeeding session
 - 3. Day 3 (49 – 72 hours): 15-30 cc per breastfeeding session
 - ii. Milk supply begins to establish between day 3-5. Mom will notice increased fullness in her breasts accompanied with increased audible swallowing.
 - b. Assessment of adequate hydration.
 - i. Acceptable weight loss up to 10%.
 - ii. Infants are expected to return to birth weight by 14 days.
 - iii. Until breast milk supply is established normal age appropriate elimination patterns are:
 - 1. Day 1: at least 1 wet, 1 stool per 24 hours.
 - 2. Day 2: 2 wets and 2 stools per 24 hours.
 - 3. Day 3: 3 wets and 3 stools per 24 hours.
 - iv. By day 4 infant should have at least 6 wet diapers and 4 yellow stools in a 24 hour period

7. Reasons for contacting the healthcare professional (i.e. Family Physician, Pediatrician, IBCLC)
 - a. Difficult, painful, or refusal latch
 - b. Inadequate wets and stools
 - c. Not waking to feed every 2-3 hours
 - d. Infant acts hungry or fussy all the time

b. Evaluation

- i. Breastfeeding assessment will be done at least once every 12 hours or more frequent if necessary using LATCH score (or other mutually agreed upon evidence based assessment tool).
- ii. Staff will document education given to mother in mother/infant medical record.

6. Mothers will be encouraged to exclusively breastfeed, unless medically contraindicated. Exclusive breastfeeding is defined as providing human milk as a sole source of nutrition. Routine supplementations (water, glucose water, formula, and other fluids) will not be given to breastfeeding infants unless specifically ordered by a physician or if the mother insists after receiving verbal and written education.
 - a. Definition: The Joint Commission defines exclusive breast milk feeding as: “a newborn receiving only breast milk and no other liquids or solids except for drops or syrups consisting of vitamins, minerals, or medicines.” Breast milk feeding includes expressed mother’s milk as well as donor human milk, both of which may be fed to the infant by means other than suckling at the breast.
 - i. In the event a mother requests non-medically indicated supplementation, staff should:
 1. Educate the mother on effective breastfeeding.
 - a. Have a direct breastfeeding evaluation of positioning, latch, and ability to transfer milk.
 - b. Be educated on normal newborn behaviors that do not require supplementation but do require breastfeeding evaluation and assistance.
 - i. Sleepy infant with fewer than 8-12 feedings in the first 24-48 hours with a normal weight loss (<8%) and no signs of illness.
 1. Instruct on skin-to-skin.
 2. Educate on normal sleep-wake cycles.
 3. Careful attention to infant’s early feeding cues and gentle awakening techniques every 2-3 hours around the clock.
 4. Encourage hand expression and/or pumping after feeding attempts if infant is not effectively latching at breast.
 - ii. Cluster feeding: Instinctive feeding patterns that often begin around 24 hours of life, demonstrating periods of frequent feeding followed by periods of rest.
 1. Instruct mother on normal infant behavior during cluster feeding.
 2. Assist on breastfeeding management that optimizes infant feeding at breast.
 - a. Skin-to-skin
 - b. Correct latch
 - c. Gentle stimulation of baby
 - d. Breast compressions
 - iii. Low-risk jaundice
 1. Healthy term AGA infants with bilirubin levels within normal limits for age who is feeding well, demonstrating age appropriate eliminations with weight loss 8%.

- a. Be provided education on risks or non-medically indicated supplementation
 - i. Altering normal intestinal flora of the infant
 - ii. Sensitizing infant to foreign proteins increasing the risk of allergies
 - iii. Disrupting supply/demand cycles leading to inadequate milk supply, delayed lactogenesis, and long-term supplementation.
 - iv. Latch difficulty if fed by artificial nipple
 - v. Causes increased maternal engorgement due to decreased frequency of feeds.
 - vi. Causes infant's stomach to stretch too quickly, interrupting the natural increasing stomach capacity.
 - vii. Shortened breastfeeding duration/early weaning
- 3. Educate the mother on alternative feeding methods (EBM)
 - a. Instruct on hand expression and/or pumping.
 - b. Instruct on finger/syringe, cup, or SNS for feeding of EBM
- 4. Non-medically indicated supplementation (Formula)
 - a. Staff will respect and support mother's informed decision on non-medically indicated supplementation.
 - b. Any supplementation should be given by finger/syringe, cup, or SNS unless mother chooses otherwise.
- ii. Medically indicated supplementation:
 - 1. Physician order is required
 - 2. Mothers own expressed milk or banked donor human milk should be encouraged when supplementation is indicated. If formula is used for supplementation hypoallergenic formula is preferred over standard formulas.
 - 3. Medically indicated supplementation may include:
 - a. Maternal delayed lactogenesis II
 - b. Abnormal weight loss
 - c. Hypoglycemia
 - d. Hyperbilirubinemia
 - e. Clinical evidence of significant dehydration
 - f. Delayed bowel movements or continued meconium stools on day 5
- iii. Medical Contraindications for breastfeeding
 - 1. Mother's medications that are unsafe for the breastfeeding infant.

2. Medical condition of mother
 - a. May be given expressed breast milk if mother has:
 - i. Untreated Tuberculosis
 - ii. Active Herpes Simplex virus on the breast
 - iii. Onset of Varicella within 5 days before or up to 48 hours after delivery until she is no longer infectious
 - b. HIV
 - c. Human T-cell lymphotropic virus Type-I or Type-II
 3. Mothers currently using illicit drugs
 4. Infants with galactosemia
 - iv. Staff shall recognize Mothers and Infants at increased risk of breastfeeding difficulty or delayed lactogenesis which may increase risk of supplementation.
 1. Cesarean delivery
 2. LGA/SGA infants
 3. Primiparas
 4. Prolonged labor
 5. Obesity
 6. Infants of diabetic mothers
 7. Postpartum hemorrhage
 8. Breast irregularities (flat/inverted nipples, surgeries, breast development, history of low milk supply, etc.)
 9. Infant conditions (down syndrome, cleft lip/palate, or other genetic disorders)
 10. Multiples
 11. Maternal hormone imbalances (i.e. PCOS)
 - v. Avoid using the term “bottle” as a synonym for formula feeding. Bottles may contained expressed or donor human milk. Formula may be given by other means besides a bottle.
- b. Evaluation
- i. Staff will document in medical record: breastfeeding assistance provided, counseling on risks of non-medically indicated supplementation, mothers educated decision.
 - ii. Handwritten information regarding supplementation will be provided.

7. Newborns will be encouraged to room-in with their mother day and night to establish successful breastfeeding.
 - a. Definition- all infants regardless of feeding method should be kept with the mother both day and night throughout the hospital stay.
 - i. Parents will be educated on the benefits of rooming-in.
 1. Promotes exclusive breastfeeding and longer breastfeeding duration
 - a. Parents learn to recognize feeding cues and feed at the earliest signs of hunger.
 - b. Infant will have uninterrupted opportunities to feed frequently therefore:
 - i. Infant's weight loss/gain is more likely to remain within normal parameters.
 - ii. Infant is less likely to become jaundice.
 2. Promotes bonding.
 3. Infants who stay near their mothers sleep better and cry less, and mothers get the same amount of sleep whether the infant is in their room or the nursery.
 4. Mother gains confidence in caring for her newborn.
 - ii. Staff will minimize infant-mother separation
 1. Conduct newborn procedures at the mother's bedside whenever possible, and should avoid frequent separation and/or absences of the newborn from the mother.
 2. If the infant must be removed from the mother's room, baby should be returned as soon as circumstances allow.
 3. If mother requests separation, infant will be brought to the mother with the first signs of hunger.
 - b. Evaluation: Education on the importance of rooming-in will be documented appropriately in the medical record.

8. Mothers will be instructed to feed their baby on demand with a minimum of 8-12 feeds in 24 hours.
 - a. Definition: Mothers should be encouraged to feed her infant per hunger cues. Healthy newborns typically feed 8-12 times in 24 hours, with some infants needing to be fed more frequently.
 - i. Birth-24 hours
 1. Infant should be fed within the first hour of life for vaginal deliveries. Post-Cesarean-birth babies will be encouraged to breastfeed as soon as possible.
 2. After initial wake period infant may become very sleepy and not interested in breastfeeding. Infant goes into a deep recuperative sleep cycle.
 3. Offer breast at least every 2-3 hours, placing infant skin-to-skin with attempts at breast to encourage a more alert infant.
 4. Normal for infants to be periodically uninterested in feeding during the first 24 hours of life. If blood sugar is within normal limits and infant has latched successfully, no intervention is needed at this time. Continue to encourage mother to offer breast every 2-3 hours.
 - ii. After 24 hours of life
 1. Infants begin to wake-up and begin to nurse more frequently. Offer both breasts at first signs of hunger cues
 2. Continue offering both breasts at each feeding but may be interested in feeding only one side at a feeding during the early days. No restrictions should be placed on the frequency or the length of feedings. Limiting feedings can lead to low milk supply, low weight gain, delayed lactogenesis, jaundice, engorgement, and/or mastitis.
 - iii. Cluster feeding often begins around 24 hours of life, and can be defined as a normal and distinctive feeding pattern.
 1. Cluster feeding occurs due to infant eating small volumes with better digestion, leading to more frequent feeds.
 2. Infant has periods of frequent feeds followed by periods of rest.
 3. Cluster feeding is a necessary instinctive feeding pattern as it helps to build mothers milk supply and establish a successful long term supply, though can be frustrating as it often occurs at night.
 4. Encourage mother to continue feeding infant on demand during these feeding patterns. Breast compressions should be encouraged throughout feeds to facilitate and increase transfer of colostrum.
 5. Mother can expect infant to behave both fussy and sleepy when at the breast. Skin-to-skin and gentle stimulation may help calm and awaken infant encouraging them to feed more effectively.
 - iv. Painful procedures
 1. Mother should be educated on infant behaviors following painful procedures (i.e. circumcision), which may temporarily affect infant feeding patterns and/or breastfeeding by making infant sleepy, uninterested in feeds, or dis-coordination of suckle. This may be followed by a period of cluster feeding.
 - b. Evaluation: Staff will document each feeding and all education provided in medical record.

9. Mothers will be instructed on not using artificial nipples or pacifiers until breastfeeding is well established (the first 3-4 weeks of life). Staff will not initiate the use of artificial nipples or pacifiers.
 - a. Definition:
 - i. Artificial nipples should not be offered to a breastfeeding infant for supplementation, sore nipples, or medications.
 1. If mother requests artificial nipple, she will be educated on how it may interfere with optimal breastfeeding if introduced before breastfeeding is well established. This may be demonstrated by refusal to breastfeed, ineffective latch, and fussiness at breast due to differences of flow between an artificial nipple and breast flow.
 2. If supplementation is medically indicated, mother will be offered a cup, syringe/feeding tube, or SNS to give additional volumes. Staff will instruct and observe one or more successful supplemental feedings.
 - ii. Pacifiers have been shown to interfere with establishment of breastfeeding and are not necessary in the early weeks.
 1. Mother will be educated on the risks of pacifier use.
 - a. Suckling at breast differs from sucking on pacifier. This may cause problems with latch therefore increasing risk of nipple tenderness
 - b. Pacifiers may mask signs of hunger and/or delay feedings, leading to excessive weight loss or dehydration.
 2. Newborns undergoing painful procedures (i.e. circumcision) may be given a pacifier as a form of pain management during the procedure. Pacifiers should be immediately discarded once procedure is complete. Alternatively, consider putting the infant to breast for heel sticks procedures.
 3. Mothers will be instructed on current recommendations of delayed pacifier use until 3-4 weeks of age, or until breastfeeding is well established.
 4. Pacifier use for preterm infants in NICU, special care units, or infants with specific medical conditions may be given pacifiers for non-nutritive sucking.
 - iii. Nipple shields
 1. Will not be routinely used to cover mother's nipples for latch problems, to prevent or manage sore or cracked nipples, or when a mother has flat or inverted nipples.
 2. Nipple shields will only be used in conjunction with an IBCLC evaluation and after other attempts to correct the latch difficulty have failed. Direct observation of feeding using a nipple shield should be done initially by an IBCLC followed by continued observation by staff.
 3. IBCLC will discuss risks of nipple shield
 - a. Low milk supply due to artificial barrier placed between infant and mother decreasing hormone release caused by a decrease in nerve stimulation.
 - b. Difficulty weaning from nipple shield

c. Risk of decrease milk transfer resulting in low weight gain and low milk supply.

4. Education will be provided on maintaining milk supply and early follow-up with healthcare professional after discharge.

iv. Nipple Soreness

1. Mothers with sore nipples will be observed for latch technique and correct latch as needed.

2. Instruct mother on hand expression and apply breast milk to nipple after each feeding and allow to air dry.

3. Lanolin or hydrogel pads may be used as appropriate.

4. Follow-up with an IBCLC if nipple soreness persists.

b. Evaluation:

i. Staff will document

1. Education on artificial nipples, pacifiers, alternative feeding methods, nipple shields, and nipple soreness

2. Observation of alternative feeding methods, use of nipple shields, and correct use of nipple treatment.

ii. Reinforcement of policy and procedures as needed.

10. Prior to going home staff will ensure all breastfeeding education is completed and provide all mothers with the names and telephone numbers of support groups and community resources that are available to help mothers with breastfeeding.
 - a. Definition: Prior to leaving the hospital breastfeeding mothers should be able to:
 - i. Identify effective breastfeeding
 1. Position and latch baby properly with no pain
 2. Be able to identify nutritive versus non-nutritive suckling and recognize swallowing
 3. State that the baby should breastfeed 8-12 times/day, with some infants needing to feed more frequently.
 4. Describe typical newborn feeding cues and state that the baby should breastfeed on demand and preferably before crying ensues.
 5. State expected elimination patterns (at least 6 wets and 4 yellow stools per 24 hours by Day 4 (73 – 96 hours old).
 6. State that the baby should be back to birth weight 10-14 days of age.
 7. Be able to hand express milk and know how to use a pump correctly, if indicated.
 8. Provide anticipatory guidance on things that may be encountered after the hospital: the management of engorgement and mastitis, signs of excess jaundice, sleep patterns, individual feeding patterns, and cluster feedings.
 - ii. If the Shared Hospital Discharge Worksheet for Breastfeeding Mothers identifies a risk factor, an infant will be referred to a health care provider or IBCLC within 24-48 hours of discharge from the hospital. Prior to discharge arrangements will be made to secure a pump for home use if needed.
 - iii. Identify indications for calling a health care professional.
 1. Staff will provide each mother with names and numbers of support groups and community resources.
 2. All breastfeeding newborns will be referred to a healthcare professional for a visit within 24-72 hours of discharge from the hospital.
 - iv. Written information will provided at discharge.
 - b. Evaluation: Staff will document all discharge education in medical record.